**IMMUNIZATION VERIFICATION OF INTERNATIONAL TRAINEE**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Date of birth |  / / |
| Nationality |  | Sex |  |
| Phone |  | E-mail |  |

**Mandatory Immunizations**

|  |
| --- |
| **1. Hepatitis B** |
| 1) Vaccination History (three doses) | Date: / / | Date: / / | Date: / / |
| 2) Immunization status | Date: / / * Immune
* Non-Immune
 | * hepatitis B carrier
 |
| **2. Varicella** |
| 1) Vaccination History (Two doses) | Date: / / | Date: / / |
| 2) Immunization status | Date: / / * Immune
* Non-Immune
 | History of disease |
| Date: / / |
| **3. MMR** |
| 1) Vaccination History [Two doses) | Date: / /  | Date: / / |
| 2) Immunization status | Measles | Mumps | Rubella |
| Date: / /* Immune
* Non-Immune
 | Date: / /* Immune
* Non-Immune
 | Date: / /* Immune
* Non-Immune
 |
| **4. Tuberculosis Screening** |
| Chest X-ray\*The result of a chest X-ray taken within 1month is required. Chest X0ray must have copy of report attached |
| Date: / / | Result | [ ]  Positive [ ]  Negative |

Hepatitis B, Varicella, MMR: Please fill out **either** vaccination history **or** immunization status.

These immunization information must be verified by a physician.

|  |
| --- |
| **I hereby certify that the above information is true and correct.**An official stamp from a doctor’s office, clinic or health department and an authorized signature must appear here or this form will not be approvedDatePhysical or Authorized SignatureOfficial Office Stamp Here |